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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DORIEN LEIGH SARLES** 1311 San Clemente Way Sacramento, California 95831 **Registered Nurse License No. 718988** **Public Health Nurse License No. 73113** Respondent.	Case No. 2011-133 **A C C U S A T I O N**

Louise R. Bailey, M.Ed. RN ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about January 31, 2008, the Board issued Registered Nurse License No. 718988, to Dorien Leigh Sarles ("Respondent"). The license was in full force and effect at all times relevant to the charges herein, and will expire on July 31, 2011, unless renewed.

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Public Health Nurse License

3. On or about April 2, 2008, the Board issued Public Health Nurse License No. 73113 to Respondent. The license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2011, unless renewed.

JURISDICTION

4. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY AND REGULATORY PROVISIONS

6. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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BACKGROUND INFORMATION

8. On or about May 10, 2009, and May 11, 2009, Respondent was employed as a Clinical Nurse II in the Accelerated Access Unit at the University of California, Davis Medical Center (UCDMC), located in Sacramento, California.

9. On or about May 10, 2009, a 64-year old female patient arrived in the emergency room complaining of inner thigh pain. The patient had a history of multiple medical problems, including hypertension, diabetes, and renal failure. The patient was examined by emergency room physicians and diagnosed as having thigh indurated areas, possibly abscesses or cellulites.

10. The patient was transferred to the Accelerated Access Unit at about 0420 hours (May 11, 2009,) where she was placed in Respondent's care.

11. At about 0445 hours, Respondent documented the patient's blood pressure at 71/31 and a heart rate of 49. The patient was complaining of being hot and sweaty.

12. At about 0505 hours, Respondent was having difficulty obtaining the patient's heart rate. Respondent attempted to take the patient's blood pressure twice using a blood pressure cuff on the patient's left arm, which had a fistula,[1] without success. Respondent contacted the charge nurse, Kwong, for assistance. Kwong placed the blood pressure cuff on the patient's right arm and immediately questioned the unstable vital signs, specifically low blood pressure. Kwong instructed Respondent to contact a physician as soon as possible. Kwong then left the patient's room to assess a new patient.

13. At about 0526 hours, Respondent administered Dilaudid to the patient because the patient was still complaining of pain.

14. At about 0530 hours, Kwong returned to check on the patient and found that Respondent had not contacted a physician, failed to recheck the patient's vital signs, and noted that the patient had drastically declined. Kwong was unable to arouse the patient and the patient was somnolent. The rapid response team and physician were contacted. When the physician

[1] A permanent abnormal passageway between two organs in the body or between an organ and the exterior of the body.

arrived, Narcan was administered to the patient in an attempt to reverse the effects of Dilaudid that Respondent had administered earlier. The patient's blood pressure was still unobtainable.

15. Between 0550-0620 hours, the rapid response team, physician, and floor staff continued their efforts to obtain the patient's vital signs, without success.

16. At about 0620 hours a code blue was called and the patient was bagged.

17. At about 0652 hours the patient expired.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

18. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that on or about May 11, 2009, while employed as a Clinical Nurse II at University of California, Davis Medical Center, located in Sacramento, California, Respondent was grossly negligent in the following respects:

a. Respondent failed to notify a physician of the patient's unstable condition and unobtainable vital signs.

b. Respondent administered an analgesic opiate (Dilaudid) to a patient with significant hypotension that had the potential of exacerbating that hypotension and potential hypoperfusion.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

19. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct, in that on or about May 11, 2009, while employed as a Clinical Nurse II at University of California, Davis Medical Center, located in Sacramento, California, Respondent demonstrated unprofessional conduct, as more particularly set forth above in paragraph 18.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 718988, issued to Dorien Leigh Sarles;

2. Revoking or suspending Public Health Nurse License No. 73113 to Dorien Leigh Sarles;

3. Ordering Dorien Leigh Sarles to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: 8/17/10

LOUISE R. BAILEY, M.ED., R.N
Interim Executive Officer
Board of Registered Nursing
State of California
Complainant

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